(X6) DATE:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PLAN OF CORRECTION (POC) IDENTIFICATION NO		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395259			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: <b>04/05/2023</b>	
	E NUMBER: 193702		-				
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0000 F 0684 SS=D	Based on a Medicare/N Survey, Civil Rights C Licensure Survey, and response to a complain 2023, it was determine Rehabilitation Center, the requirements of 42 Requirements for Long 28 PA Code, Common Term Care Licensure R health portion of the su	an Abbreviated Survey, a an Abbreviated Survey, t, completed on Apred that Statesman He was not in complian CFR Part 483, Subpost Term Care Facilities wealth of Pennsylva Regulations related to	and State vey in il 5, alth and ce with oart B, es and the inia Long	F 0684			
I ABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ED DEDDECENTATIVE'S SIGN	ATUDE		TITLE:	(X6) DATE:	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 1 of 11

	OF DEFICIENCIES AND RECTION (POC)			EY			
STATESM CENTER	VIDER OR SUPPLIER:  AN HEALTH & REHABII  JE NUMBER: 193702	LITATION	STREET ADDRESS, 2629 TRENTO LEVITTOWN	ON ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY ( IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 1  483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundame treatment and care provided the comprehensive assessme must ensure that residents re accordance with professiona comprehensive person-cente residents' choices.  This REQUIREMENT is no	to facility residents. Batent of a resident, the faceceive treatment and caral standards of practice, ered care plan, and the	ised on ility e in	F 0684	F 684- Facility failed to follow for three of seven residents reviewed.  Step 1 - R12 Oxygen administration corrected to 2LPM. Assessed adverse effect. None observed and RP notified. Nurse education correct way to assess for LPI delivery.  R30 Orders received from N change foley catheter size to cc.  R31 was assessed for adverse with no substantial findings identified. MD and RP notified orders received to adjust medications to those present hand. Nurse educated on me administration process with emphasis on correct drug and Step 2 - All residents receiving supple oxygen have the potential to affected. On 4/5/2023 the D Nursing (DON) and/or design audited all residents receiving oxygen to ensure the ordered Per Minute (LPM) matched	d for ed. MD eated on M  IP to 0 16F 5 se effect  ied. New tly on edication d dose. lemental be Director of gnee ng d Liters	Completion Date: 04/26/2023 Status: APPROVED Date: 04/21/2023

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 2 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395259				04/05/2023	
STATESM CENTER	VIDER OR SUPPLIER:  AN HEALTH & REHABII  SEE NUMBER: 193702	LITATION	STREET ADDRESS, 2629 TRENTO LEVITTOWN	ON ROAD			
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F 0684	Continued from page 2			F 0684			
SS=D					provided by the oxygen concentrator. No issues ident All residents requiring the us indwelling foley catheter hav potential to be affected. On the DON and/or designee audresident's with foley catheter ensure the size utilized matel size ordered. No issues ident All residents receiving medic have the potential to be affect 4/22/2023, the DON and/or of will complete a medication administration audit for all listaff to ensure correct process observed.  Step 3 – To prevent the potent reoccurrence the DON and/or designee re-educated all licenstaff on the medication administration process with emphasis on ensuring dose at are correct.  Licensed staff educated on prechnique of assessing for coadministration of oxygen LP concentrator.  Licensed staff educated on he identify an indwelling foley of	se of an we the 4/5/2023 dited all s to hed the tified. cation cted. On designee censed ss is ntial for or nsed  and drug roper orrect M on ow to	

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 3 of 11

· · · · · · · · · · · · · · · · · · ·		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00_		(X3) DATE SURVEY COMPLETED:	
		395259				04/05/2023	
STATESM CENTER	VIDER OR SUPPLIER:  AN HEALTH & REHABII  E NUMBER: 193702	LITATION	STREET ADDRESS, 2629 TRENTO LEVITTOWN	ON ROAD			
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F 0684 SS=D	Continued from page 3			F 0684	size.  Step 4 – To monitor and mai ongoing compliance the DOI designee will observe the oxyconcentrators for 3 random r 1 time a week to ensure that settings match the physician' If necessary, the O2 concentr will be corrected, and the resummediately responsible staff member immediately re-educated. The DON and/or designee w observe 3 residents with fole catheters 1 time a week to ensize matches the physicians of necessary, the MD and RP will be notified, and the responsible member immediately re-educated. The DON and/or designee will responsible member immediately re-educated of the physicians of necessary, the MD and RP will be carried of replace or otherwise) as recently as recently designee will randomly medication administration for nurses 1 time a week for 3 minecessary, a resident evaluation	N and/or ygen esidents the s order. ration sident The and the  ill y sure the order. If rill be staff cated. ut (to ived. r observe or 2 sonths. If	
					be completed, the MD and R notified, and new orders obta Responsible nurse will be		

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 4 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395259				04/05/2023	
STATESM CENTER	VIDER OR SUPPLIER:  AN HEALTH & REHABIL	JITATION	STREET ADDRESS, 2629 TRENTO LEVITTOWN	ON ROAD			
STATE LICENSE NUMBER: 193702  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 4			F 0684			
SS=D					re-educated at time of observ Results of the audits will be presented to facility QAPI Committee for review and recommendations.	ation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395259			<u>uv</u>	04/05/2023	
STATESM CENTER	VIDER OR SUPPLIER: AN HEALTH & REHABIL	LITATION	STREET ADDRESS, 2629 TRENTO LEVITTOWN	ON ROAD			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0684 SS=D	CNTER  TE LICENSE NUMBER: 193702  4) ID  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OF THE PRECEDED BY FULL REGULATORY OF THE PRECEDED BY FULL REGUL		predures, was physician ed. (R12, ur of the at 8:56 wed in revealed ading at evealed lity on iagnoses onary	F 0684			
	airflow and make it dif	-					

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 6 of 11

PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00  B. WING:		(X3) DATE SURVEY COMPLETED:	
		395259		B. WING: _		04/05/2023	
STATESM CENTER	VIDER OR SUPPLIER:  AN HEALTH & REHABIL  E NUMBER: 193702	LITATION	STREET ADDRESS, 2629 TRENTO LEVITTOWN	ON ROAD			
(X4) ID	SUMMARY STATEMENT	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)	
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH	CORRECTIVE ACTION SHOULD BE COME ROSS-REFERENCED TO THE APPROPRIATE	
F 0684	Continued from page 6			F 0684			
SS=D							
	Respiratory Failure (oc						
	the lungs cannot releas						
	blood), and Anxiety Disorder (A mental health						
	disorder characterized	•					
	or fear that are strong e	vith one's					
	daily activities).						
	Review of resident R12	2's Admission MDS					
	Assessment Section Co	)500 BIMS score (B	rief				
	Interview of Mental Sta	atus) dated March 4	, 2023,				
	revealed a score of 12 s						
	was moderately impair	•					
	(C) Special Treatments		grams				
	revealed that resident F	R12 was on oxygen.					
	Review of Resident R1	2's care plan reveale	ed a plan				
	of care for CHF and Ox	•	<b>.</b>				
	Review of Resident R1						
	order revealed a curren		at 2LPM				
	(liters/minute) every sh	nift.					
	Follow-up observation	of Resident R12, co	onducted				

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 7 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395259			<u></u>	04/05/2023	
STATESM CENTER	VIDER OR SUPPLIER:  AN HEALTH & REHABII  JE NUMBER: 193702	LITATION	STREET ADDRESS, 2629 TRENTO LEVITTOWN	ON ROAD			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0684 SS=D	on April 4, 2023, 12:33 Nursing confirmed that flow meter at eye level Review of the clinical revealed that the reside on March 7, 2022 with Multiple Sclerosis (a d system eats away at the nerves, and it causes mincluding vision loss, proordination), and Neuroland System and bladder (Neuromuscul happens when the relatisystem and bladder fur disease).  On April 5, 2023, at 10 observed with a urinary size, and 5 CC balloon sterile tube that is insert drain urine from the bloobstruction of normal to the sterile tube of the sterile of the steri	t, the oxygen concert was 1.5 liters/minuterecords of Resident 2 ent was admitted to the R30 diagnoses of isease in which the ise protective covering any different symptonian, fatigue, and impromuscular Dysfunction of Britishing between the action is disrupted by 0:49 a.m., Resident Fly foley catheter with adder of individuals	R30 he facility of mmune g of oms, paired etion of ladder nervous y injury or R30 was 15 FR is a ladder to with	F 0684			

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 8 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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F 0684 SS=D	held in place with a ba with sterile water to premoved from the blad to measure the size of FR.; it is the measure of catheter).  Review of physician of for Resident R30, indican indwelling urinary for 10 CC Balloon.  On April 5, 2023, at 10 with Licensed nurse, Exthat the catheter size of not the catheter size of not the catheter size of Review of the clinical revealed that the reside on September 5, 2022, Fibromyalgia (widespreaderness), and Polyn malfunction of many preserved.	event the catheter froder; the French scale a catheter and abbrevent the outer diameter of the outer diameter and attended from the outer diameter attended that there was a foley catheter with 1 of the outer diameter and outer diameter diameter at was admitted to the outer diagnoses of the outer diagnoses outer diagnoses outer diagnoses outer diagnoses outer diagnoses o	om being e is used viated as of a  7, 2023, order for 8 FR, with  interview confirmed R30 was an.  R31 he facility of Itaneous	F 0684			

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 9 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395259		A. BLDG: _ B. WING: _	00	04/05/2023	
NAME OF PROVIDER OR SUPPLIER: STATESMAN HEALTH & REHABILITATION CENTER STATE LICENSE NUMBER: 193702			STREET ADDRESS, 2629 TRENTO LEVITTOWN	ON ROAD			
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 9			F 0684			
SS=D	the body).  On April 5, 2023, at 8:15 a.m., it was observed a Licensed Nurse, Employee E3, administered Ferrous Sulfate Oral Tablet, 325 milligrams (mg), by mouth to Resident R31. (Ferrous Sulfate Tablet is an iron supplement used to treat or prevent low Iron levels in blood).  Review of physician order dated, December 7, 2022, for Resident R31, revealed an order for Ferrous Gluconate Tablet 324 (38 Fe) mg, give 1 tablet, by mouth, every 12 hours, every Monday, Wednesday, Friday for anemia.  Further review of medication literature indicated; the main difference between Ferrous Sulfate and						
	Ferrous Gluconate is he contain; Ferrous Sulfat weight, while Ferrous Glemental iron by weight On April 5, 2023, at 8:	e is 20% elemental i Gluconate is around ht.	ron by				

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 10 of 11

		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER:	ER: A. BLDG:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 04/05/2023			
NAME OF PROVIDER OR SUPPLIER:  STATESMAN HEALTH & REHABILITATION  CENTER  STATE LICENSE NUMBER: 193702			STREET ADDRESS, CITY, STATE, ZIP CODE: 2629 TRENTON ROAD LEVITTOWN, PA 19056						
(X4) ID PREFIX TAG	X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF REFIX MUST BE PRECEEDED BY FULL REGULATORY OR			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
F 0684 SS=D			locaine 31. er 29, for ly, one E3, at the vations. nt.	F 0684					

CMS-2567L EGYC11 IF CONTINUATION SHEET Page 11 of 11



# **Certified End Page**

#### STATESMAN HEALTH & REHABILITATION CENTER

STATE LICENSE NUMBER: 193702 SURVEY EXIT DATE: 04/05/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

#### **PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY